Children's Surgical Associates, P.C.

755 Mount Vernon Highway NE Suite 460, Atlanta, GA, 30328

PLEASE PRINT LEGIBLY

Child's Full Legal Name: _____

Age: _____ Date of Birth: _____ Birth Weight: _____ Nickname: _____

Sex: _____ Current Height : _____ Current Weight: _____

Who referred you to our office? _____

Who is your child's pediatrician (if different from above)? _____

Why are you here today? _____

When did you first notice/problem begin? _____

The CHILD'S general health is: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

Are the CHILD'S immunizations up to date? ☐ **YES** ☐ **NO**

If NO, please specify: _____

MEDICATIONS

List all medications, including supplements your CHILD is currently taking:

List all medications your CHILD is ALLERGIC to:

PAST MEDICAL HISTORY

List all surgeries your child has had, when, and where:

List all hospitalizations other than for surgery indications why, when, and where:

FAMILY HISTORY

Please check the appropriate disorder that is found in your family history:

- ☐ Bleeding Problems/Prolonged Bleeding
- ☐ Problems with Anesthesia/Sedation
- ☐ Cancer
- ☐ Genetic Disorders/Syndromes
- ☐ Sickle Cell Anemia or Sickle Cell Trait
- ☐ Other

Please specify if any of the above are checked:

_____

List siblings and ages: _____

Is there a smoker living in the home of the child? ☐ **YES** ☐ **NO**

If yes, please list: _____

Does your home utilize: ☐ **CITY WATER** ☐ **WELL WATER**

REVIEW OF SYSTEMS

BIRTH HISTORY

- ☐ Prematurity: ☐ Weeks Gestation: _____ OR ☐ Weeks Early: _____
- ☐ C-section
- ☐ Apnea Monitor
- ☐ Other _____

HEART OR BLOOD PROBLEMS ☐ YES ☐ NO

- ☐ Heart Defect
- ☐ Bleeding Problems
- ☐ Sickle Cell Disease/Trait
- ☐ HIV Positive
- ☐ Other _____

LUNG OR BREATHING PROBLEMS ☐ YES ☐ NO

- ☐ Asthma/Wheezing
- ☐ Croup
- ☐ Chronic Bronchitis
- ☐ Cystic Fibroids
- ☐ Other _____

DIGESTIVE SYSTEM PROBLEMS ☐ YES ☐ NO

- ☐ Hepatitis
- ☐ Intestines/Bowels
- ☐ Liver
- ☐ Gastro-esophageal Reflux
- ☐ Stomach
- ☐ Other _____

NERVOUS SYSTEM PROBLEMS ☐ YES ☐ NO

- ☐ Convulsions, Seizures, or Fits
- ☐ Cerebral Palsy
- ☐ Hydrocephalus
- ☐ Down's Syndrome
- ☐ Myelomeningocele
- ☐ Developmental Delay
- ☐ Learning Disability
- ☐ Other _____

MUSCLE OR BONE/JOINT PROBLEMS ☐ YES ☐ NO

- ☐ Muscle Disorder
- ☐ Bone Disease
- ☐ Joint Disease
- ☐ Rheumatoid Arthritis
- ☐ Other _____

KIDNEY OR BLADDER PROBLEMS ☐ YES ☐ NO

- ☐ Explain _____

GLANDULAR PROBLEMS ☐ YES ☐ NO

- ☐ Diabetes
- ☐ Thyroid
- ☐ Other _____

HAS MENSTRUATION STARTED? ☐ YES ☐ NO

Date of last menstrual period: _____

CANCER/CHEMOTHERAPY ☐ YES ☐ NO

If yes, please explain: _____

OTHER PROBLEMS OR SYNDROMES ☐ YES ☐ NO

If yes, please explain: _____

Patient Profile

PATIENT INFORMATION

Name: _____

Preferred: _____

Address:

_____

City/State/Zip: _____

Alt Address:

_____

Alt City/State/Zip: _____

Phone: _____ ☐ HOME ☐ WORK ☐ CELL

Phone: _____ ☐ HOME ☐ WORK ☐ CELL

Phone: _____ ☐ HOME ☐ WORK ☐ CELL

Sex: ☐ MALE ☐ FEMALE

Date of Birth: _____

SSN #: _____

Marital Status: ☐ MARRIED ☐ SINGLE ☐ DIVORCED

Referring/Primary Physician: _____

Phone: _____

Pharmacy: _____

Phone: _____

Race: _____

Ethnicity: _____

Email Address: _____

PATIENT EMPLOYMENT

☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED ☐ OTHER

Phone: _____

Employer: _____

GUARANTOR

☐ Same as patient

Name: _____

Address:

_____

City/State/Zip: _____

EMERGENCY CONTACTS

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

GUARANTOR'S EMPLOYMENT

Employer: _____

Employer Phone: _____

Alt Phone: _____

SSN #: _____

Date of Birth: _____

MEDICAID

Medicaid/Peachstate/Amerigroup/Wellcare/Caresource

Medicaid/Peachstate #: _____

AMG/Wellcare/Caresource #: _____

PRIMARY INSURANCE

Insurance Name: _____

Ins ID#: _____

Group #: _____

Policy Holder:

☐ SAME AS PATIENT ☐ GUARANTOR ☐ OTHER

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder SSN#: _____

SECONDARY INSURANCE

Insurance Name: _____

Ins ID#: _____

Group#: _____

Policy Holder:

☐ SAME AS PATIENT ☐ GUARANTOR ☐ OTHER

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder SSN#: _____

CHILDREN'S SURGICAL ASSOCIATES, P.C.

Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that Children's Surgical Associates has a Privacy Policy in place in Accordance with the Health Insurance Portability and Accountability ACT of 1996 (HIPPA). As a patient of Children's Surgical Associates, I understand and acknowledge the following:

- ✓ Children's Surgical Associates has a privacy policy in effect in their office.
- ✓ Children's Surgical Associates has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
- ✓ Children's Surgical Associates has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by Children's Surgical Associates and have read and understood the acknowledgement form.

If you desire a copy of the Privacy Policy, please request one at this time.

☐ **No, I do not want a copy, but acknowledge the Privacy Policy exists.**

☐ **Yes, I do want a copy of the Privacy Policy.**

_____

Patient Signature (Guardian if patient is a minor)

Patient Agreement for Communication

I understand that as part of my healthcare, Children's Surgical Associates will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize Children's Surgical Associates to contact me in the following ways (Check those which you authorize):

- ☐ **HOME PHONE:** _____ ☐ **VOICEMAIL OK**
- ☐ **WORK PHONE:** _____ ☐ **VOICEMAIL OK**
- ☐ **CELL PHONE:** _____ ☐ **VOICEMAIL OK**
- ☐ **FAX:** _____
- ☐ **EMAIL ADDRESS:** _____

Children's Surgical Associates does not use secure server for e-mail communication. Because a secure server is required by law for e-mail communication with patients, Children's Surgical Associates does not endorse the use of email communication with patients.

I understand that Children's Surgical Associates will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past conversations. I further authorize Children's Surgical Associates to discuss matters related to my condition/care with the following:

_____ _____

(Please Print) Relationship to patient

_____ _____

(Please Print) Relationship to patient

_____ _____

Signature (Guardian if patient is a minor) Date

Children's Surgical Associates Financial Responsibility Policy

CO-PAYMENTS _____ (Initial)

All office visits require a co-payment from your insurance company. Exceptions may include post-operative visits for a determined period of time for some surgical procedures. Some insurance plans require co-payments for post-operative visits.

DEDUCTIBLE _____ (Initial)

A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a co-payment is required for the visit. In addition, some services and procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same surgery to the insurance company, and are billed as surgery.

NO SHOW _____ (Initial)

Patients who fail to show for their scheduled appointment, procedure, or surgery are subject to a No Show penalty. These penalties are as follows:

- ✓ **$25 for missed appointments if 1 business days' notice is not given.**
- ✓ **$150 for office procedures if 3 business days' notice is not given.**
- ✓ **$300 for surgery if a business weeks' notice is not given.**

GUARANTEE OF PAYMENT FOR SERVICES & ASSIGNMENT OF BENEFITS _____ (Initial)

It is the policy of the office that you must pay for services when rendered except in the cases of surgery where a prepay may be required. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. If you have any questions, please ask about this before leaving the office. In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus a $25 surcharge for collections. I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release my medical information in the processing of this claim.

INSURANCE COVERAGE _____ (Initial)

I am aware that my insurance has been verified and that there is a disclaimer which states my insurance does not guarantee payments, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

REFERRAL WAIVER _____ (Initial)

I understand that if my insurance requires a referral for my visit, I am responsible for making sure that the referral is obtained from my primary care physician. I also understand that if the referral from the primary care physician's office is not received before/on the day of my appointment, I agree to pay for all services rendered on the day of the visit.

ADMINISTRATIVE FEES _____ (Initial)

It is the policy of the office that you must pay for medical records as they are requested. All medical records must be approved by the doctor before they can be sent. The fees for medical records are as follows:

- ✓ **Medical records (ie office notes, operative notes, etc): $20.00 each request**
- ✓ **Third Party Administrative Forms (ie disability, FMLA, life insurance, etc): $20.00 each form**
- ✓ **School Excuses (if requested after leaving office): $5.00 each request**
- ✓ **All medical records are automatically sent to the primary care/referring physician with no charge**

_____

Signature (Guardian If patient is a minor) (Print Name)

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SURGICAL ASSOCIATES

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